Allen Okie MD FACAI. FAAP **CLSC**
https://aokiemd.com
904-465-7882 cell; Fax: 904-212-0623

Allergy Questionnaire

Referring PCP_____
Clinic:_____
Cell Phone:_____
Email:_____

Name Last:_____First:_____

Member ID Number _____Date_____

If you have any questions email aokiemd@gmail.com Fax 904-212-0623

Age: _____ Sex: ☐ Male ☐ Female Birthplace: _____ PCP:_____

email:_____

1)Circle All that applies.

Nose None: ☐	**Throat None:** ☐	**Ears None:** ☐	**Eyes None:** ☐	**Head None:** ☐
itchy nose sneezing congestion decreased smell/taste snoring runny nose - if yes, is the *nasal discharge:* ☐ *clear* ☐ *colored*	sore throat itchy throat or palate throat clearing cough hoarseness post-nasal drainage – if yes, is the *drainage:* ☐ *clear* ☐ *colored*	itchy ears plugged ears ringing hearing loss nasal polyps	itchy eyes watery eyes red eyes dry/irritated eyes swollen lids discharge	headache facial pressure or pain

2) When did your symptoms **first** begin? _____ When, if so, did they **get worse**?_____

3) Are your symptoms: ☐ seasonal* ☐ all year long ☐ all year long, with seasonal worsening*

* *check the **worst months**:* ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

4) Check the things that make your symptoms worse:

Irritants	**Weather**	**Medicine**	**Allergens**	**Location**	**Other**
☐ smoke ☐ air pollution ☐ fumes or car exhaust ☐ strong odors or perfumes	☐ cold air ☐ rapid temperature change *(e.g. going from cold outdoors to indoor heat)*	☐ aspirin ☐ non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)*	☐ grass ☐ dust or vacuuming ☐ damp or musty area ☐ animals, if so specify: _____	☐ outdoors ☐ indoors ☐ daycare ☐ home ☐ school ☐ work	☐ _____ _____ _____ _____ _____ _____

5) Have you had any of the following **problems** or **procedures**: ** If yes, specify* **Yes***

frequent ear infections ☐ PE tubes ☐ nasal or sinus surgery ☐ nasal polyps ☐ broken nose ☐
frequent sinus infections ☐ (how many in a year?_____

ALLERGIC REACTION TO A STING, DRUG, FOOD or other SUBSTANCE ***If none, skip to next section***
If yes fill in below

1) **What** did you react to? _____ If stung, **where** on your body were you stung? _____

2) **When** did the reaction occur? *(date and time of day)* _____

3) **Length of time** from exposure (or sting/injection) until onset of symptoms: _____

4) **How long** did your symptoms last? _____

5) Briefly **describe** the reaction: _____

_____

6) **Have you ever had a serve reaction (anaphylaxis)**_Yes☐(fill in below) No☐ Skip to next section

7) Please check any of the following **symptoms** you had with your reaction:

☐ shortness of breath ☐ tongue swelling ☐ hoarseness or change in voice
☐ dizziness or loss of consciousness ☐ wheezing or chest tightness ☐ throat tightness or trouble swallowing
☐ flushing ☐ abdominal cramping, diarrhea or vomiting

7) Did you get **medical attention**? ☐ **Yes*** ☐ No

* *If yes, was it from:* ☐ Emergency Room ☐ Urgent Care ☐ Clinic ☐ 911/Medics

8) **Treatment** (if any) you received: _____

9) Do you have a **current EpiPen**? ☐ Yes ☐ No

Proceed to next page

CHEST or ASTHMA SYMPTOMS ***Have you had (chck) Chronic Cough*** ☐ ***Wheezing*** ☐ ***Bronchitis*** ☐

If any of the above is checked fill in below. **If nothing above skip to next section Eczema - Atopic Dermatitis**

1) Check all that apply what is the worst:_____
☐ shortness of breath ☐ wheezing ☐ chest pain or tightness ☐ coughing up blood
☐ recurrent or chronic cough – if yes, is the cough: ☐ wet/productive ☐ dry

2) When did your symptoms **first** begin? _____ When, if so, did they **get worse**? _____

3) Are your symptoms: ☐ seasonal* ☐ all year long ☐ all year long, with seasonal* worsening?
* *Circle **worst months**:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) **How often** do you have symptoms? ☐ 2 or less times a week ☐ once a day
☐ 3–6 times a week ☐ throughout the day

5) Do these symptoms **disturb your sleep**? ☐ **Yes*** ☐ No
*If yes, how often? ☐ 2 or less times a month ☐ 3–4 times a month ☐ 2–6 times a week ☐ every night

6) Do your symptoms ever **interfere with exercise** or **daily activities**? ☐ **Yes*** ☐ No
* If yes, what activity? _____

7) Have your symptoms forced you to **miss work** or **school**? *(Circle which one)* ☐ **Yes*** ☐ No
* If yes, how many times in the past 12 months? _____

8) Have your symptoms caused you to go to the **Emergency Room** or **Urgent Care**? ☐ **Yes*** ☐ No
* If yes, how many visits in the past 12 months? _____

9) Have your symptoms caused you to be **admitted** overnight to the hospital? ☐ **Yes*** ☐ No
* If yes, how many times? ____ Were you ever in the Intensive Care Unit? ☐ Yes ☐ No

10) Have you ever needed treatment with an oral or injectable **steroid**? *(e.g. prednisone)* ☐ **Yes*** ☐ No
* If yes, when was your last course of steroids? _____

11) Check the things that make your **chest symptoms worse**:

Irritants	**Infections**	**Weather**	**Medicine**	**Allergens**	**Location**	**Other**
☐ smoke ☐ fumes/car exhaust ☐ air pollution ☐ strong odors or perfumes	☐ colds or flu ☐ sinus infections ☐ I get a yearly Flu Shot	☐ cold air ☐ weather changes ☐ heat	☐ aspirin ☐ non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)*	☐ grass ☐ dust/vacuuming ☐ damp or musty areas ☐ animals, If yes, specify: _____	☐ outdoors ☐ indoors ☐ home ☐ daycare ☐ school ☐ work: _____	☐ exercise ☐ emotion/ stress ☐ laughing ☐ other: _____

12) Have you ever had pneumonia? ☐ **Yes*** ☐ No * If yes, how many times? _____

13) Have you had a **chest X-ray** since your symptoms began? ☐ **Yes*** ☐ No * If yes, when? _____

14) Do you have symptoms of **heartburn or acid reflux**? ☐ **Yes*** ☐ No * If yes, how often? _____

If you've been prescribed <u>albuterol</u> or have <u>asthma</u>, please answer the following questions:

1) How many **puffs** of albuterol do you use **per week**? _____

2) How many **canisters** of albuterol have you used in the past 6 months?_____

3) Do you have a home peak flow meter? Yes ☐ No ☐

4) Do you monitor your **peak flows**? ☐ **Yes*** ☐ No
   1. If yes,
   2. What has been the **range** of your peak flow readings over the past 2 weeks? _____

ECZEMA **Atopic Dermatitis** Do you have a recurrent rash? Yes ***If no, skip to next section***

1) When did your eczema **first** begin? _____ When, if so, did it **get worse**? _____

2) What **parts of your body** are most affected? _____

3) Are your symptoms: ☐ seasonal* ☐ all year long ☐ all year long, with seasonal worsening*

Circle **worst months:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your **eczema worse**:

Irritants	**Allergens**	**Foods**	**Other:**
☐ soaps ☐ tight clothing ☐ detergents ☐ cosmetics ☐ wool ☐ sun ☐ heat	☐ dust ☐ mold ☐ pollen ☐ animals: _____	☐ milk ☐ nuts ☐ soy ☐ wheat ☐ eggs ☐ peanuts ☐ other: _____	☐ Infection ☐ _____

Proceed to next page

Do you have **HIVES or SWELLING** **Yes** ***If no, skip to next section* **Part Two**

1) What is your main **problem**? □ hives □ swelling □ hives and swelling

2) What **parts of your body** are affected? _____

3) When did your symptoms **first** begin? _____ When was your **last outbreak**? _____

4) On the average, **how long** does each outbreak last? _____

5) **How often** do outbreaks occur? □ daily ___ times a week ___ times a month ___ times a year

6) **If you have hives, how long** does each individual hive last? □ less than 24 hours □ more than 24 hours

7) Check any **symptoms you have with hives**: □ itching □ burning □ tingling □ pain □ bruising

8) Check all that apply: Symptoms worse in the: □ spring □ summer □ autumn □ winter
Symptoms worse in the: □ morning □ afternoon □ evening □ night
Symptoms worse in the: □ outdoors □ indoors □ home □ school □ daycare □ work
Symptoms worse during: □ weekdays □ weekends □ menstrual cycle

9) During an outbreak, do you have any of the following **symptoms**? □ **Yes*** □ No * *If yes, check box.*
□ shortness of breath □ flushing □ tongue swelling □ throat tightness or trouble swallowing
□ wheezing or chest tightness □ hoarseness or change in voice □ dizziness or loss of consciousness
□ joint pain □ fever □ swollen glands □ diarrhea, vomiting or abdominal pain

10) Check the things that make your **symptoms worse**:

Exposure to:	**Medicines**	**Allergens**	**Other**
□ exercise □ cold air □ sunlight □ heat (shower/bath) □ rubbing or scratching □ vibration (mowing lawn, motorcycling)	□ aspirin □ non-steroidal anti-inflammatory agents (e.g. Motrin, Advil, Aleve) □ ACE inhibitors (e.g. lisinopril) □ other medicines: _____	□ grass □ dust or vacuuming □ wooded areas □ damp or musty area □ latex (balloons, condoms, dental work, latex gloves) □ animals, specify: _____ □ foods or food additives, specify:_____	□ emotion or stress □ other: _____

11) Check the box if the following **events** happened soon before your symptoms started:
□ mononucleosis □ jaundice or hepatitis □ sore throat or strep throat □ sinus infection
□ swollen lymph glands □ urinary tract infection □ toothache or gum infection □ bee sting
□ pneumonia □ thyroid problems □ ulcers or gastritis
□ fungal infection of skin, scalp, or nails □ impetigo or skin infection
□ transfusion □ immunization, specify: _____
□ recent move from another area; from where? _____
□ job change, specify: _____
□ change of residence □ foreign travel, where? _____
□ other: _____

Part 2: Please answer all of the remaining questions

Medicines

List **all** prescription and over-the-counter medicines you're currently taking that you Include oral, inhaled, injected, drops, sprays, suppositories, creams and ointments.

Name of medicine	Strength (if known)	Dose and number of times taken per day

Are you on Any Heart Medications: ☐ Yes Please List

Allergy History

1) Have you had previous allergy **skin testing**? □ **Yes*** □ No * *If yes, when?* _____

2) Have you ever received **allergy shots**? □ **Yes*** □ No * *If yes, specify the years you received them:*
From _____ to _____ Additional years: From _____ to _____ From _____ to _____
Were the shots helpful? □ Yes □ No Did you have any bad reactions? □ Yes □ No

3) Do you have allergies to any foods? □ **Yes*** □ No * *If yes, specify:*

Name of food	Allergic reaction(s)	Approximate date of reaction(s)

Proceed to next page

Past Medical History

1) Check the box if you've had any of the following:
□ glaucoma □ cataracts □ depression □ high blood pressure
□ diabetes □ tuberculosis □ positiveTB test □ peptic (stomach) ulcer
□ AIDS or HIV □ kidney disease □ aseptic necrosis □ osteoporosis □ heart problems
□ other significant medical problems: _____

2) Please list all **surgeries and hospital stays:** (followed by approximate date)

_____ _____ _____
_____ _____ _____
_____ _____ _____

3) Have you **ever smoked**? □ **Yes*** □ No * *If yes, specify.*
Are you: □ a **current** smoker? □ a **past** smoker? **Quit date:** _____
What and **how long** did you smoke? □ cigarettes: ____ years **Packs per day:** _____
□ cigars: ___ years □ pipe: ___ years

4) Does **anyone** in your home smoke? □ **Yes*** □ No * *If yes, specify.*
□ mother □ father □ spouse or partner □ son □ daughter
□ brother □ sister □ roommate □ other: _____

Family History

Please place a check mark for each relative with the following medical problems:

* *If more than one relative has the same medical problem, place a check mark for each one.*

Example: 2 brothers with asthma:

Medical Problem	*Mother*	*Father*	*Brother*
Asthma			✓✓

Medical Problem	Mother	Father	Brother	Sister	Son	Daughter	Grandmother	Grandfather
Asthma								
Emphysema								
Nasal allergy								
Sinus problems								
Eczema								

Environmental History

1) What is/was your **occupation** or, if you are still a student, your **grade** in school? _____
2) What are your **hobbies**? _____
3) **How long** have you lived at your present location? _____ years
4) **Location**: □ downtown □ urban □ suburb □ rural/country
5) **Type of home**: □ house □ apartment/condo □ houseboat □ mobile home □ other: _____
6) **Type of heating**: radiant forced air heat pump wood burning stove pellet stove other: _____
8) **Air conditioning**: none central window units
9) **Air filter**: □ HEPA □ electrostatic
10) **Floor**: Bedroom: □ carpeting □ wood/laminate □ tile □ cement □ other: _____
11) **Mattress**: □ regular □ foam □ air mattress □ waterbed □ futon
12) **Pillow**: □ synthetic □ foam □ down □ feather □ cotton □ other: _____
13) **Comforter**: □ none □ down □ synthetic □ feather □ other: _____
14) Do you have zippered dustmite **allergy covers (encasements)**? □ **Yes*** □ No * *If yes, what item is covered?*
□ pillows □ mattress □ comforter □ box springs
15) Do you have any **pets**? □ **Yes*** □ No * *If yes, check all that apply and how many of each animal.*
□ cat(s) #___ □ dog(s) #___ □ bird(s) #___ other: _____

16) Do you have a **mold** or **mildew** problem in your home? Yes* No *If yes, is it a minor problem? major problem?

Would you consider your problems ▢ **Mild** ▢ □**Moderate** ▢ **Severe**

If you would like a Virtual Visit with the Allergist Contact your PCP or Call

_____